MEDICAL RECORDS RELEASE

OBGYN
Obstetrics & Gynecology
Associates, Inc.

Today's Date _____

I hereby authorize Obstetrics & Gynecology Associates, Inc. to:

RELEASE MY ENTIRE MEDICAL RECORD TO:

Physician, Facility, or Self: _____

Address: _____

City_____ State _____Zip code _____

Reason for Release:

____ Specialist Appointment (Please specify date) _____

____ Leaving Practice (Please specify reason) _____

____ Other (Please specify reason) _____

____ At the request of the individual

-OR-

OBTAIN FROM:

Physician or Facility: _____

Address: _____

City _____ State _____ Zip code _____

Phone #: _____ Fax #: _____

I understand that my records may contain information regarding the diagnosis or treatment of HIV, Aids virus, other sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. I give my authorization for these records to be released:

- ☐ **HIV/AIDS**
- ☐ **Sexually transmitted diseases**
- ☐ **Mental illness or mental health treatment**
- ☐ **Drug and alcohol abuse treatment**

Patient's Name (print) _____Birthdate _____

Patient's Signature _____

Please note: There is a retrieval fee of $18.91 for any records having to be obtained from our off-site storage facility. Payment of this retrieval fee will be due prior to the retrieval of your records. There will also be a charge for a subsequent copy of medical records. We suggest you make a copy of your records prior to releasing them to another physician.

Please allow 3 business days for electronic transmission and up to 14-21 business days to receive your paper chart records.

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